

AMENDED IN ASSEMBLY APRIL 5, 2010

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

**ASSEMBLY BILL**

**No. 2244**

---

**Introduced by Assembly Member Feuer**

February 18, 2010

---

~~An act to amend Section 13291 of the Government Code, relating to state government.~~ *An act to add Article 11.7 (commencing with Section 1399.825) to Chapter 2.2 of Division 2 of the Health and Safety Code, and to add Chapter 9.7 (commencing with Section 10950) to Part 2 of Division 2 of the Insurance Code, relating to health care coverage.*

LEGISLATIVE COUNSEL'S DIGEST

AB 2244, as amended, Feuer. ~~State finance.~~ *Health care coverage.*

*Existing law provides for the licensing and regulation of health care service plans by the Department of Managed Health Care. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes a health care service plan or health insurer to exclude an applicant from coverage for a specified time for preexisting conditions. A willful violation of provisions governing health care service plans is a crime.*

*This bill would require all health care service plans and insurance carriers that offer health care coverage to children or individuals to offer that coverage, by specified dates, to any child or individual seeking coverage. The bill would also prohibit, by specified dates, the exclusion or limitation of coverage due to any preexisting condition. The bill would further establish and require the implementation of standard risk rates with respect to plan contracts or health benefit plans that provide coverage to children, as specified. The bill would authorize the*

*Department of Managed Health Care and the Department of Insurance to adopt emergency regulations for purposes of implementation.*

*By imposing new requirements on health care service plans, the willful violation of which would be a crime, this bill would impose a state-mandated local program.*

*The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.*

*This bill would provide that no reimbursement is required by this act for a specified reason.*

~~Existing law authorizes the Department of Finance to require certain state agencies to produce financial and statistical reports on forms provided by the department.~~

~~This bill would make a technical, nonsubstantive change to this provision.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~-yes.  
State-mandated local program: ~~no~~-yes.

*The people of the State of California do enact as follows:*

1     SECTION 1. Article 11.7 (commencing with Section 1399.825)  
2     is added to Chapter 2.2 of Division 2 of the Health and Safety  
3     Code, to read:

4  
5             Article 11.7. Individual Access to Health Care

6  
7     1399.825. As used in this article:

8     (a) (1) "Child" means any individual under 19 years of age.

9     (2) "Responsible party for a child" means an adult having  
10    custody of a child with the right to make medical decisions for,  
11    and with the responsibility for the financial needs of, the child.

12    (b) "Individual" means any individual over 19 years of age.

13    (c) "In force business" means an existing health benefit plan  
14    contract issued by the plan to an individual.

15    (e) "New business" means a health care service plan contract  
16    issued to an individual that is not the plan's in force business.

17    (f) "Preexisting condition provision" means a contract provision  
18    that excludes coverage for charges or expenses incurred during  
19    a specified period following the individual's effective date of

1 coverage, as to a condition for which medical advice, diagnosis,  
2 care, or treatment was recommended or received during a specified  
3 period immediately preceding the effective date of coverage.

4 (g) "Rating period" means the period for which premium rates  
5 established by a plan are in effect and shall be no less than 12  
6 months.

7 (h) "Risk adjusted individual risk rate" means the rate  
8 determined for an eligible individual or child in a particular risk  
9 category after applying the risk adjustment factor.

10 (i) "Risk adjustment factor" means the percentage adjustment  
11 to be applied equally to each standard risk rate for a particular  
12 child, based upon any expected deviations from standard cost of  
13 services. This factor may not be more than 120 percent or less  
14 than 80 percent until January 1, 2012. Effective January 1, 2012,  
15 this factor may not be more than 110 percent or less than 90  
16 percent. Effective January 1, 2014, the standard risk rate shall  
17 apply to all policies sold to individuals or for children.

18 (j) "Risk category" means the following characteristics of an  
19 eligible child: age, geographic region, and family composition of  
20 the individual, plus the health benefit plan selected by the  
21 individual.

22 (1) Until January 1, 2014, no more than the following age  
23 categories may be used in determining premium rates:

24 (A) Under age 5.

25 (B) Age 5-15.

26 (C) Age 15-19.

27 (2) The rate shall not vary by more than 2 to 1 for children.

28 (3) Individual health care service plans shall base rates for  
29 individuals and children using no more than the following family  
30 size categories:

31 (A) Single.

32 (B) Married couple.

33 (C) One adult and child or children.

34 (D) Married couple and child or children.

35 (4) In determining rates for individuals and children, a plan  
36 that operates statewide shall use the geographic regions specified  
37 in Section 1357.

38 (k) Nothing in this section shall be construed to require a plan  
39 to establish a new service area or to offer health coverage on a  
40 statewide basis, outside of the plan's existing service area.

1     1399.826. (a) (1) Effective January 1, 2011, every health care  
2 service plan offering plan contracts for children shall offer  
3 coverage to the responsible party for any child that seeks coverage.

4     (2) Effective January 1, 2014, every health care service plan  
5 offering plan contracts to individuals shall offer coverage to any  
6 individual who seeks coverage.

7     (b) (1) Effective January 1, 2011, notwithstanding any other  
8 provision of state law or regulation, every health care service plan  
9 offering contracts for children shall not exclude or limit coverage  
10 due to any preexisting condition.

11     (2) Effective January 1, 2014, notwithstanding any other  
12 provision of state law or regulation, every health care service plan  
13 offering contracts for children shall not exclude or limit coverage  
14 due to any preexisting condition.

15     (c) This article shall not apply to coverage to which an employer  
16 makes any contribution.

17     (d) Every health care service plan offering plan contracts to  
18 individuals shall in addition to complying with the provisions of  
19 this chapter and the rules adopted thereunder comply with the  
20 provisions of this article.

21     1399.827. This article shall not apply to health plan contracts  
22 for coverage of Medicare services pursuant to contracts with the  
23 United States government, Medicare supplement, Medi-Cal  
24 contracts with the State Department of Health Services, Healthy  
25 Families, long-term care coverage, or specialized health plan  
26 contracts.

27     1399.828. (a) Upon the effective date of this article, a health  
28 care service plan shall fairly and affirmatively offer, market, and  
29 sell all of the plan's health care service plan contracts that are  
30 offered and sold to the responsible party for a child. Effective  
31 January 1, 2014, a health care service plan shall fairly and  
32 affirmatively offer, market, and sell all of the plan's health care  
33 service plan contracts that are sold to individuals.

34     (b) Effective January 1, 2011, a health care service plan shall  
35 not reject an application from the responsible party for a child for  
36 a health care service plan contract. Effective January 1, 2014, a  
37 health care service plan shall not reject an application from an  
38 individual for a health care service plan contract.

39     (c) No health care service plan or solicitor shall, directly or  
40 indirectly, engage in the following activities:

1     *(1) Encourage or direct an individual or responsible party for*  
2     *a child to refrain from filing an application for coverage with a*  
3     *plan because of the health status, claims experience, industry,*  
4     *occupation of the individual or child, or geographic location*  
5     *provided that it is within the plan's approved service area.*

6     *(2) Encourage or direct individuals or children to seek coverage*  
7     *from another plan because of the health status, claims experience,*  
8     *industry, occupation of the individual or child, or geographic*  
9     *location, provided that it is within the plan's approved service*  
10    *area.*

11    *(d) A health care service plan shall not, directly or indirectly,*  
12    *enter into any contract, agreement, or arrangement with a solicitor*  
13    *that provides for or results in the compensation paid to a solicitor*  
14    *for the sale of a health care service plan contract to be varied*  
15    *because of the health status, claims experience, industry,*  
16    *occupation, or geographic location of the individual or child. This*  
17    *subdivision does not apply to a compensation arrangement that*  
18    *provides compensation to a solicitor on the basis of percentage of*  
19    *premium, provided that the percentage shall not vary because of*  
20    *the health status, claims experience, industry, occupation, or*  
21    *geographic area of the individual or child.*

22    *(e) Effective January 1, 2011, a health care service plan contract*  
23    *that covers a child shall not establish rules for eligibility, including*  
24    *continued eligibility, of an individual, or dependent of an*  
25    *individual, to enroll under the terms of the plan based on any of*  
26    *the following health status-related factors:*

27    *(1) Health status.*

28    *(2) Medical condition, including physical and mental illnesses.*

29    *(3) Claims experience.*

30    *(4) Receipt of health care.*

31    *(5) Medical history.*

32    *(6) Genetic information.*

33    *(7) Evidence of insurability, including conditions arising out*  
34    *of acts of domestic violence.*

35    *(8) Disability.*

36    *(9) Any other health status-related factor determined*  
37    *appropriate by department.*

38    *(f) A health care service plan shall comply with the requirements*  
39    *of Section 1374.3.*

1 (g) *Effective January 1, 2014, this section shall apply to all*  
2 *individuals and children obtaining coverage with no contribution*  
3 *from an employer.*

4 1399.829. (a) *After an individual or the responsible party for*  
5 *a child submits a completed application form for a plan contract,*  
6 *the health care service plan shall, within 30 days, notify the*  
7 *individual or responsible party for a child of actual premium*  
8 *charges for that plan contract established in accordance with*  
9 *Section 1399.836. The individual or responsible party for a child*  
10 *shall have 30 days in which to exercise the right to buy coverage*  
11 *at the quoted premium charges.*

12 (b) *When an individual or the responsible party for a child*  
13 *submits a premium payment, based on the quoted premium charges,*  
14 *and that payment is delivered or postmarked, whichever occurs*  
15 *earlier, within the first 15 days of the month, coverage under the*  
16 *plan contract shall become effective no later than the first day of*  
17 *the following month. When that payment is neither delivered nor*  
18 *postmarked until after the 15th day of a month, coverage shall*  
19 *become effective no later than the first day of the second month*  
20 *following delivery or postmark of the payment.*

21 (c) *During the first 60 days after the effective date of the plan*  
22 *contract, the individual or responsible party for a child shall have*  
23 *the option of changing coverage to a different plan contract offered*  
24 *by the same health care service plan. If an individual or the*  
25 *responsible party for a child notifies the plan of the change within*  
26 *the first 15 days of a month, coverage under the new plan contract*  
27 *shall become effective no later than the first day of the following*  
28 *month. If an individual or the responsible party for a child notifies*  
29 *the plan of the change after the 15th day of a month, coverage*  
30 *under the new plan contract shall become effective no later than*  
31 *the first day of the second month following notification.*

32 1399.830. (a) *Effective January 1, 2011, a health care service*  
33 *plan may not exclude any child who would otherwise be entitled*  
34 *to health care services on the basis of an actual or expected health*  
35 *condition of that child. No health care service plan contract may*  
36 *limit or exclude coverage for a child by type of illness, treatment,*  
37 *medical condition, or accident.*

38 (b) *Effective January 1, 2014, a health care service plan may*  
39 *not exclude any individual who would otherwise be entitled to*  
40 *health care services on the basis of an actual or expected health*

1 *condition of that individual. No health care service plan contract*  
2 *may limit or exclude coverage for a child by type of illness,*  
3 *treatment, medical condition, or accident.*

4 *1399.831. All health care service plan contracts offered to an*  
5 *individual or child shall provide to subscribers and enrollees at*  
6 *least all of the basic health care services in this act.*

7 *1399.832. No health care service plan shall be required to*  
8 *offer a health care service plan contract or accept applications*  
9 *for the contract pursuant to this article in the case of any of the*  
10 *following:*

11 *(a) To an individual or child, if the individual or child who is*  
12 *to be covered by the plan contract does not work or reside within*  
13 *the plan's approved service areas.*

14 *(b) (1) Within a specific service area or portion of a service*  
15 *area, if the plan reasonably anticipates and demonstrates to the*  
16 *satisfaction of the director that it will not have sufficient health*  
17 *care delivery resources to ensure that health care services will be*  
18 *available and accessible to the individual or child because of its*  
19 *obligations to existing enrollees.*

20 *(2) A health care service plan that cannot offer a health care*  
21 *service plan contract to individuals or children because it is lacking*  
22 *in sufficient health care delivery resources within a service area*  
23 *or a portion of a service area may not offer a contract in the area*  
24 *in which the plan is not offering coverage to individuals to new*  
25 *employer groups until the plan notifies the director that it has the*  
26 *ability to deliver services to individuals, and certifies to the director*  
27 *that from the date of the notice it will enroll all individuals*  
28 *requesting coverage in that area from the plan unless the plan has*  
29 *met the requirements of subdivision (d).*

30 *(3) Nothing in this article shall be construed to limit the*  
31 *director's authority to develop and implement a plan of*  
32 *rehabilitation for a health care service plan whose financial*  
33 *viability or organizational and administrative capacity has become*  
34 *impaired.*

35 *(c) Offer coverage to an individual or child that, within 12*  
36 *months of application for coverage, disenrolled from a plan*  
37 *contract offered by the plan.*

38 *(d) (1) The director approves the plan's certification that the*  
39 *number of eligible employees and dependents enrolled under*

1 *contracts issued during the current calendar year equals or exceeds*  
2 *either of the following:*

3 *(A) In the case of a plan that administers any self-funded health*  
4 *coverage arrangements in California, 10 percent of the total*  
5 *enrollment of the plan in California as of December 31 of the*  
6 *preceding year.*

7 *(B) In the case of a plan that does not administer any self-funded*  
8 *health coverage arrangements in California, 8 percent of the total*  
9 *enrollment of the plan in California as of December 31 of the*  
10 *preceding year. If that certification is approved, the plan shall not*  
11 *offer any health benefit plan to any small employers during the*  
12 *remainder of the current year.*

13 *(2) If a health care service plan treats an affiliate or subsidiary*  
14 *as a separate carrier for the purpose of this article because one*  
15 *health care service plan is qualified under the federal Health*  
16 *Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and*  
17 *does not offer coverage to small employers, while the affiliate or*  
18 *subsidiary offers a plan contract that is not qualified under the*  
19 *federal Health Maintenance Organization Act (42 U.S.C. Sec.*  
20 *300e et seq.) and offers plan contracts to small employers, the*  
21 *health care service plan offering coverage to small employers shall*  
22 *enroll new eligible employees and dependents, equal to the*  
23 *applicable percentage of the total enrollment of both the health*  
24 *care service plan qualified under the federal Health Maintenance*  
25 *Organization Act (42 U.S.C. Sec. 300e et seq.) and its affiliate or*  
26 *subsidiary.*

27 *(3) (A) The certified statement filed pursuant to this subdivision*  
28 *shall state the following:*

29 *(i) Whether the plan administers any self-funded health coverage*  
30 *arrangements in California.*

31 *(ii) The plan's total enrollment as of December 31 of the*  
32 *preceding year.*

33 *(iii) The number of eligible employees and dependents enrolled*  
34 *under contracts issued to small employer groups during the current*  
35 *calendar year.*

36 *(B) The director shall, within 45 days, approve or disapprove*  
37 *the certified statement. If the certified statement is disapproved,*  
38 *the plan shall continue to issue coverage as required by Section*  
39 *1357.03 and be subject to disciplinary action as set forth in Article*  
40 *7 (commencing with Section 1386).*



1     1399.833. *The director may require a health care service plan*  
2 *to discontinue the offering of contracts or acceptance of*  
3 *applications from any individual or child upon a determination*  
4 *by the director that the plan does not have sufficient financial*  
5 *viability or organizational and administrative capacity to ensure*  
6 *the delivery of health care services to its enrollees. In determining*  
7 *whether the conditions of this section have been met, the director*  
8 *shall consider, but not be limited to, the plan's compliance with*  
9 *the requirements of Section 1367, Article 6 (commencing with*  
10 *Section 1375.1), and the rules adopted under those provisions.*

11     1399.834. *All health care service plan contracts offered to a*  
12 *child or individual shall be renewable at the option of the enrollee*  
13 *or responsible party for a child except:*

14     (a) *For nonpayment of the required premiums by the enrollee*  
15 *or responsible party for a child.*

16     (b) *For fraud or misrepresentation by the individuals or their*  
17 *representatives.*

18     (c) *When the health care service plan ceases to provide or*  
19 *arrange for the provision of health care services for new individual*  
20 *health care service plan contracts in this state; provided, however,*  
21 *that the following conditions are satisfied:*

22     (1) *Notice of the decision to cease new or existing individual*  
23 *health benefits plans in this state is provided to the director and*  
24 *to the contractholder at least 360 days prior to the discontinuation*  
25 *of the coverage.*

26     (2) *Individual health care service plan contracts subject to this*  
27 *article shall not be canceled for 360 days after the date of the*  
28 *notice required under paragraph (1) and for that business of a*  
29 *plan which remains in force, any plan that ceases to offer for sale*  
30 *new individual health care service plan contracts shall continue*  
31 *to be governed by this article with respect to business conducted*  
32 *under this article.*

33     (3) *Except as authorized under subdivision (d) of Section*  
34 *1399.832 or Section 1399.833, a plan that ceases to write new*  
35 *individual business in this state after the effective date of this*  
36 *article shall be prohibited from offering for sale new individual*  
37 *health care service plan contracts in this state for a period of five*  
38 *years from the date of notice to the director.*

39     (d) *When the health care service plan withdraws a health care*  
40 *service plan contract from the individual market; provided, the*

1 plan notifies all affected contractholders and the director at least  
2 180 days prior to the discontinuation of those contracts, and the  
3 plan makes available to the individual all plan contracts that it  
4 makes available to new individual business; and provided, that  
5 the premium for the new plan contract complies with the renewal  
6 increase requirements set forth in Section 1399.836.

7 1399.836. Effective January 1, 2011, premiums for contracts  
8 offered or delivered by health care service plans on or after the  
9 effective date of this article for children shall be subject to the  
10 following requirements:

11 (a) The premium for new business shall be determined for an  
12 eligible child in a particular risk category after applying a risk  
13 adjustment factor to the plan's standard risk rates. The risk  
14 adjusted risk rate may not be more than 120 percent or less than  
15 80 percent of the plan's applicable standard risk rate until January  
16 1, 2012. Effective January 1, 2012, this factor may not be more  
17 than 110 percent or less than 90 percent. The standard risk rates  
18 applied to a child for new business shall be in effect for no less  
19 than 12 months.

20 (b) (1) The premium for in force business shall be determined  
21 for an eligible child in a particular risk category after applying a  
22 risk adjustment factor to the plan's standard individual risk rates.  
23 The risk adjusted individual risk rates may not be more than 120  
24 percent or less than 80 percent of the plan's applicable standard  
25 risk rate until January 1, 2011. Effective January 1, 2012, this  
26 factor may not be more than 110 percent or less than 90 percent.  
27 The factor effective January 1, 2011, shall apply to in force  
28 business at the earlier of either the time of renewal or January 1,  
29 2012. The risk adjustment factor applied to a child may not  
30 increase by more than 10 percentage points from the risk  
31 adjustment factor applied in the prior rating period. The risk  
32 adjustment factor for a child may not be modified more frequently  
33 than once every 12 months.

34 (2) The standard risk rates shall be in effect for no less than 12  
35 months.

36 (3) For a contract that a plan has discontinued offering, the  
37 risk adjustment factor applied to the standard risk rates for the  
38 first rating period of the new contract that the responsible party  
39 for the child elects to purchase shall be no greater than the risk  
40 adjustment factor applied in the prior rating period to the

1 *discontinued contract. However, the risk adjusted individual risk*  
2 *rate may not be more than 120 percent or less than 80 percent of*  
3 *the plan's applicable standard risk rate until January 1, 2012.*  
4 *Effective January 1, 2012, this factor may not be more than 110*  
5 *percent or less than 90 percent. The factor effective January 1,*  
6 *2012, shall apply to in force business at the earlier of either the*  
7 *time of renewal or January 1, 2012. The risk adjustment factor for*  
8 *a child may not be modified more frequently than once every 12*  
9 *months.*

10 *1399.837. Health care service plans shall apply standard risk*  
11 *rates consistently with respect to all children.*

12 *1399.838. In connection with the offering for sale of any plan*  
13 *contract for children, each plan shall make a reasonable*  
14 *disclosure, as part of its solicitation and sales materials, of the*  
15 *following:*

16 *(a) The extent to which premium rates for a specific child are*  
17 *established or adjusted in part based upon the actual or expected*  
18 *variation in service costs or actual or expected variation in health*  
19 *condition of the child.*

20 *(b) The provisions concerning the plan's right to change*  
21 *premium rates and the factors, other than provision of services*  
22 *experience, that affect changes in premium rates.*

23 *(c) Provisions relating to the guaranteed issue and renewal of*  
24 *contracts.*

25 *(d) Provisions relating to the child's right to apply for any*  
26 *contract written, issued, or administered by the plan at the time*  
27 *of application for a new health care service plan contract, or at*  
28 *the time of renewal of a health care service plan contract.*

29 *(e) The availability, upon request, of a listing of all the plan's*  
30 *contracts and benefit plan designs offered for children, including*  
31 *the rates for each contract.*

32 *(f) At the time it offers a contract to the responsible party for a*  
33 *child, each plan shall provide the responsible party with a*  
34 *statement of all of its plan contracts offered to children, including*  
35 *the rates for each plan contract, in the service area in which the*  
36 *individuals who are to be covered by the plan contract reside. For*  
37 *purposes of this subdivision, plans that are affiliated plans or that*  
38 *are eligible to file a consolidated income tax return shall be treated*  
39 *as one health plan.*

40 *(g) Each health care service plan shall do all of the following:*

1     (1) Prepare a brochure that summarizes all of its plan contracts  
2     offered to children and to make this summary available to any  
3     responsible party for a child and to solicitors upon request. The  
4     summary shall include for each contract information on benefits  
5     provided, a generic description of the manner in which services  
6     are provided, such as how access to providers is limited, benefit  
7     limitations, required copayments and deductibles, standard risk  
8     rates, and a phone number that can be called for more detailed  
9     benefit information. Plans are required to keep the information  
10    contained in the brochure accurate and up to date and, upon  
11    updating the brochure, send copies to solicitors and solicitor firms  
12    with whom the plan contracts to solicit enrollments or  
13    subscriptions.

14    (2) For each contract, prepare a more detailed evidence of  
15    coverage and make it available to responsible parties, solicitors,  
16    and solicitor firms upon request. The evidence of coverage shall  
17    contain all information that a prudent buyer would need to be  
18    aware of in making contract selections.

19    (3) Provide to responsible parties and solicitors, upon request,  
20    for any given child the standard risk rates. When requesting this  
21    information, responsible parties, solicitors, and solicitor firms  
22    shall provide the plan with the information the plan needs to  
23    determine the individual's risk adjusted risk rate.

24    (4) Provide copies of the current summary brochure to all  
25    solicitors and solicitor firms contracting with the plan to solicit  
26    enrollments or subscriptions from responsible parties for children.

27    For purposes of this subdivision, plans that are affiliated plans  
28    or that are eligible to file a consolidated income tax return shall  
29    be treated as one health plan.

30    (h) Every solicitor or solicitor firm contracting with one or more  
31    plans to solicit enrollments or subscriptions from responsible  
32    parties for children shall do all of the following:

33    (1) When providing information on contracts to a responsible  
34    party for a child or children but making no specific  
35    recommendations on particular plan contracts:

36    (A) Advise the responsible party of the plan's obligation to sell  
37    to any responsible party any plan contract it offers for children  
38    and provide them, upon request, with the actual rates that would  
39    be charged for that child for a given contract.

1 (B) Notify the responsible party that the solicitor or solicitor  
2 firm will procure rate and benefit information for the responsible  
3 party for the child on any plan contract offered by a plan whose  
4 contract the solicitor sells.

5 (C) Notify the responsible party that upon request the solicitor  
6 or solicitor firm will provide the responsible party with the  
7 summary brochure required under this paragraph for any plan  
8 contract offered by a plan with whom the solicitor or solicitor firm  
9 has contracted to solicit enrollments or subscriptions.

10 (2) When recommending a particular benefit plan design or  
11 designs, advise the responsible party that, upon request, the agent  
12 will provide the responsible party with the brochure required by  
13 paragraph (1) containing the benefit plan design or designs being  
14 recommended by the agent or broker.

15 (3) Prior to filing an application for a responsible party for a  
16 child for a particular contract:

17 (A) For each of the plan contracts offered by the plan whose  
18 contract the solicitor or solicitor firm is offering, provide the  
19 responsible party with the benefit summary required in paragraph  
20 (1) and the standard risk rates for that particular child.

21 (B) Notify the responsible party that, upon request, the solicitor  
22 or solicitor firm will provide the responsible party with an evidence  
23 of coverage brochure for each contract the plan offers.

24 (C) Notify the responsible party for a child that, from January  
25 1, 2011, to January 1, 2012, actual rates may be 20 percent higher  
26 or lower than the standard risk rates, and from January 1, 2012,  
27 until December 31, 2014, actual rates may be 10 percent higher  
28 or lower than the standard risk rates, depending on how the plan  
29 assesses the risk of the child.

30 (D) Notify the responsible party that, upon request, the solicitor  
31 or solicitor firm will submit information to the plan to ascertain  
32 the child's risk adjusted risk rate for any contract the plan offers.

33 (E) Obtain a signed statement from the responsible party  
34 acknowledging that the responsible party has received the  
35 disclosures required by this section.

36 1399.839. (a) At least 30 business days prior to renewing or  
37 amending a plan contract subject to this article that will be in  
38 force on the operative date of this article, a plan shall file a notice  
39 of material modification with the director in accordance with the  
40 provisions of Section 1352. The notice of material modification

1 shall include a statement certifying that the plan is in compliance  
2 with subdivision (j) of Section 1399.825 and Section 1399.836.  
3 The certified statement shall set forth the standard risk rate for  
4 each risk category and the highest and lowest risk adjustment  
5 factors that will be used in setting the rates at which the contract  
6 will be renewed or amended. Any action by the director, as  
7 permitted under Section 1352, to disapprove, suspend, or postpone  
8 the plan's use of a plan contract shall be in writing, specifying the  
9 reasons that the plan contract is not in compliance with the  
10 requirements of this chapter.

11 (b) At least 30 business days prior to offering a plan contract  
12 subject to this article, all plans shall file a notice of material  
13 modification with the director in accordance with the provisions  
14 of Section 1352. The notice of material modification shall include  
15 a statement certifying that the plan is in compliance with  
16 subdivision (j) of Section 1399.825 and Section 1399.836. The  
17 certified statement shall set forth the standard risk rate for each  
18 risk category and the highest and lowest risk adjustment factors  
19 that will be used in setting the rates at which the contract will be  
20 offered. Plans that will be offering to a responsible party for a  
21 child contracts approved by the director prior to the effective date  
22 of this article shall file a notice of material modification in  
23 accordance with this subdivision. Any action by the director, as  
24 permitted under Section 1352, to disapprove, suspend, or postpone  
25 the plan's use of a plan contract shall be in writing, specifying the  
26 reasons that the plan contract is not in compliance with the  
27 requirements of this chapter.

28 (c) Prior to making any changes in the risk categories, risk  
29 adjustment factors, or standard risk rates filed with the director  
30 pursuant to subdivision (a) or (b), the plan shall file, as an  
31 amendment, a statement setting forth the changes and certifying  
32 that the plan is in compliance with subdivision (j) of Section  
33 1399.825 and Section 1399.836. A plan may commence offering  
34 plan contracts utilizing the changed risk categories set forth in  
35 the certified statement on the 45th day from the date of the filing,  
36 or at an earlier time determined by the director, unless the director  
37 disapproves the amendment by written notice, stating the reasons  
38 therefor. If only the standard risk rate is being changed, and not  
39 the risk categories or risk adjustment factors, a plan may  
40 commence offering plan contracts utilizing the changed standard

1 risk rate upon the 31st day after filing the certified statement unless  
2 the director disapproves the amendment by written notice.

3 (d) Periodic changes to the standard risk rate that a plan  
4 proposes to implement over the course of up to 12 consecutive  
5 months may be filed in conjunction with the certified statement  
6 filed under subdivision (a), (b), or (c).

7 (e) Each plan shall maintain at its principal place of business  
8 all of the information required to be filed with the director pursuant  
9 to this section.

10 (f) Each plan shall make available to the director, on request,  
11 the risk adjustment factor used in determining the rate for any  
12 particular child.

13 (g) Nothing in this section shall be construed to limit the  
14 director's authority to enforce the rating practices set forth in this  
15 article.

16 1399.840. The director may issue regulations that are necessary  
17 to carry out the purposes of this article. Prior to the public  
18 comment period required by regulations under the Administrative  
19 Procedure Act (Chapter 3.5 (commencing with Section 11340) of  
20 Part 1 of Division 3 of Title 2 of the Government Code), the  
21 director shall provide the Insurance Commissioner with a copy of  
22 the proposed regulations. The Insurance Commissioner shall have  
23 30 days to notify the director in writing of any comments on the  
24 regulations. The Insurance Commissioner's comments shall be  
25 included in the public notice issued on the regulations. Any rules  
26 and regulations adopted pursuant to this article may be adopted  
27 as emergency regulations in accordance with the Administrative  
28 Procedure Act. Until December 31, 2015, the adoption of these  
29 regulations shall be deemed an emergency and necessary for the  
30 immediate preservation of the public peace, health and safety, or  
31 general welfare. Any regulations adopted prior to December 31,  
32 2015, in order to remain in effect after December 31, 2016, shall  
33 be readopted as nonemergency regulations in accordance with  
34 the Administrative Procedures Act prior to December 31, 2016.

35 SEC. 2. Chapter 9.7 (commencing with Section 10950) is added  
36 to Part 2 of Division 2 of the Insurance Code, to read:

37  
38 CHAPTER 9.7. INDIVIDUAL ACCESS TO HEALTH INSURANCE  
39

40 10950. As used in this article:

1 (a) (1) “Child” means any individual under 19 years of age.

2 (2) “Responsible party for a child” means an adult having  
3 custody of a child with the right to make medical decisions for,  
4 and with the responsibility for the financial needs of, the child.

5 (b) “Individual” means any individual over 19 years of age.

6 (c) “In force business” means an existing health benefit plan  
7 issued by a carrier to an individual.

8 (e) “New business” means a health benefit plan issued to an  
9 individual that is not the carrier’s in force business.

10 (f) “Preexisting condition provision” means a contract provision  
11 that excludes coverage for charges or expenses incurred during  
12 a specified period following the individual’s effective date of  
13 coverage, as to a condition for which medical advice, diagnosis,  
14 care, or treatment was recommended or received during a specified  
15 period immediately preceding the effective date of coverage.

16 (g) “Rating period” means the period for which premium rates  
17 established by a carrier are in effect and shall be no less than 12  
18 months.

19 (h) “Risk adjusted individual risk rate” means the rate  
20 determined for an eligible individual or child in a particular risk  
21 category after applying the risk adjustment factor.

22 (i) “Risk adjustment factor” means the percentage adjustment  
23 to be applied equally to each standard risk rate for a particular  
24 child, based upon any expected deviations from standard cost of  
25 services. This factor may not be more than 120 percent or less  
26 than 80 percent until January 1, 2012. Effective January 1, 2012,  
27 this factor may not be more than 110 percent or less than 90  
28 percent. Effective January 1, 2014, the standard risk rate shall  
29 apply to all policies sold to individuals or for children.

30 (j) “Risk category” means the following characteristics of an  
31 eligible child: age, geographic region, and family composition of  
32 the individual, plus the health benefit plan selected by the  
33 individual.

34 (1) Until January 1, 2014, no more than the following age  
35 categories may be used in determining premium rates:

36 (A) Under age 5.

37 (B) Age 5-15.

38 (C) Age 15-19.

39 (2) The rate shall not vary by more than 2 to 1 for children.



1     (3) Carriers shall base rates for individuals and children using  
2     no more than the following family size categories:

3     (A) Single.

4     (B) Married couple.

5     (C) One adult and child or children.

6     (D) Married couple and child or children.

7     (4) In determining rates for individuals and children, a carrier  
8     that operates statewide shall the geographic regions specified in  
9     Section 10700.

10    (k) Nothing in this section shall be construed to require a carrier  
11    to establish a new service area or to offer health coverage on a  
12    statewide basis, outside of the carrier's existing service area.

13    10951. (a) (1) Effective January 1, 2011, every carrier offering  
14    health benefit plans for children shall offer coverage to the  
15    responsible party for any child that seeks coverage.

16    (2) Effective January 1, 2014, every carrier offering health  
17    benefit plans to individuals shall offer coverage to any individual  
18    who seeks coverage.

19    (b) (1) Effective January 1, 2011, notwithstanding any other  
20    provision of state law or regulation, every carrier offering  
21    contracts for children shall not exclude or limit coverage due to  
22    any preexisting condition.

23    (2) Effective January 1, 2014, notwithstanding any other  
24    provision of state law or regulation, every carrier offering  
25    contracts for children shall not exclude or limit coverage due to  
26    any preexisting condition.

27    (c) This article shall not apply to coverage to which an employer  
28    makes any contribution.

29    (d) Every carrier offering health benefit plans to individuals  
30    shall in addition to complying with the provisions of this chapter  
31    and the rules adopted thereunder comply with the provisions of  
32    this article.

33    10952. This article shall not apply to health benefit plans for  
34    coverage of Medicare services pursuant to contracts with the  
35    United States government, Medicare supplement, Medi-Cal  
36    contracts with the State Department of Health Services, Healthy  
37    Families, long-term care coverage, or specialized health benefit  
38    plans.

39    10953. (a) Upon the effective date of this article, a carrier  
40    shall fairly and affirmatively offer, market, and sell all of the

1 carrier's contracts that are offered and sold to the responsible  
2 party for a child. Effective January 1, 2014, a carrier shall fairly  
3 and affirmatively offer, market, and sell all of the carrier's  
4 contracts that are sold to individuals.

5 (b) Effective January 1, 2011, a carrier shall not reject an  
6 application from the responsible party for a child for a health  
7 benefit plan. Effective January 1, 2014, a carrier shall not reject  
8 an application from an individual for a health benefit plan.

9 (c) No carrier or solicitor shall, directly or indirectly, engage  
10 in the following activities:

11 (1) Encourage or direct an individual or responsible party for  
12 a child to refrain from filing an application for coverage with a  
13 carrier because of the health status, claims experience, industry,  
14 occupation of the individual or child, or geographic location  
15 provided that it is within the carrier's approved service area.

16 (2) Encourage or direct individuals or children to seek coverage  
17 from another carrier because of the health status, claims  
18 experience, industry, occupation of the individual or child, or  
19 geographic location, provided that it is within the carrier's  
20 approved service area.

21 (d) A carrier shall not, directly or indirectly, enter into any  
22 contract, agreement, or arrangement with a solicitor that provides  
23 for or results in the compensation paid to a solicitor for the sale  
24 of a health benefit plan to be varied because of the health status,  
25 claims experience, industry, occupation, or geographic location  
26 of the individual or child. This subdivision does not apply to a  
27 compensation arrangement that provides compensation to a  
28 solicitor on the basis of percentage of premium, provided that the  
29 percentage shall not vary because of the health status, claims  
30 experience, industry, occupation, or geographic area of the  
31 individual or child.

32 (e) Effective January 1, 2011, a health care service health  
33 benefit plan that covers a child shall not establish rules for  
34 eligibility, including continued eligibility, of an individual, or  
35 dependent of an individual, to enroll under the terms of the carrier  
36 based on any of the following health status-related factors:

37 (1) Health status.

38 (2) Medical condition, including physical and mental illnesses.

39 (3) Claims experience.

40 (4) Receipt of health care.

1 (5) *Medical history.*

2 (6) *Genetic information.*

3 (7) *Evidence of insurability, including conditions arising out*  
4 *of acts of domestic violence.*

5 (8) *Disability.*

6 (9) *Any other health status-related factor determined*  
7 *appropriate by department.*

8 (f) *A carrier shall comply with the requirements of subdivision*  
9 *(c) of Section 10119.*

10 (g) *Effective January 1, 2014, this section shall apply to all*  
11 *individuals and children obtaining coverage with no contribution*  
12 *from an employer.*

13 10954. (a) *After an individual or the responsible party for a*  
14 *child submits a completed application form for a health benefit*  
15 *plan, the carrier shall, within 30 days, notify the individual or*  
16 *responsible party for a child of actual premium charges for that*  
17 *health benefit plan established in accordance with Section 10960.*  
18 *The individual or responsible party for a child shall have 30 days*  
19 *in which to exercise the right to buy coverage at the quoted*  
20 *premium charges.*

21 (b) *When an individual or the responsible party for a child*  
22 *submits a premium payment, based on the quoted premium charges,*  
23 *and that payment is delivered or postmarked, whichever occurs*  
24 *earlier, within the first 15 days of the month, coverage under the*  
25 *health benefit plan shall become effective no later than the first*  
26 *day of the following month. When that payment is neither delivered*  
27 *nor postmarked until after the 15th day of a month, coverage shall*  
28 *become effective no later than the first day of the second month*  
29 *following delivery or postmark of the payment.*

30 (c) *During the first 60 days after the effective date of the health*  
31 *benefit plan, the individual or responsible party for a child shall*  
32 *have the option of changing coverage to a different health benefit*  
33 *plan offered by the same carrier. If an individual or the responsible*  
34 *party for a child notifies the carrier of the change within the first*  
35 *15 days of a month, coverage under the new health benefit plan*  
36 *shall become effective no later than the first day of the following*  
37 *month. If an individual or the responsible party for a child notifies*  
38 *the carrier of the change after the 15th day of a month, coverage*  
39 *under the new health benefit plan shall become effective no later*  
40 *than the first day of the second month following notification.*

1     10955. (a) Effective January 1, 2011, a carrier may not exclude  
2     any child who would otherwise be entitled to health care services  
3     on the basis of an actual or expected health condition of that child.  
4     No health care service health benefit plan may limit or exclude  
5     coverage for a child by type of illness, treatment, medical  
6     condition, or accident.

7     (b) Effective January 1, 2014, a carrier may not exclude any  
8     individual who would otherwise be entitled to health care services  
9     on the basis of an actual or expected health condition of that  
10    individual. No health care service health benefit plan may limit  
11    or exclude coverage for a child by type of illness, treatment,  
12    medical condition, or accident.

13    10956. All health benefit plans offered to an individual or child  
14    shall provide to contractholders and insureds at least all of the  
15    basic health care services in this act.

16    10957. No carrier shall be required to offer a health benefit  
17    plan or accept applications for the contract pursuant to this article  
18    in the case of any of the following:

19    (a) To an individual or child, if the individual or child who is  
20    to be covered by the health benefit plan does not work or reside  
21    within the carrier's approved service areas.

22    (b) (1) Within a specific service area or portion of a service  
23    area, if the carrier reasonably anticipates and demonstrates to the  
24    satisfaction of the commissioner that it will not have sufficient  
25    health care delivery resources to ensure that health care services  
26    will be available and accessible to the individual or child because  
27    of its obligations to existing insureds.

28    (2) A carrier that cannot offer a health benefit plan to  
29    individuals or children because it is lacking in sufficient health  
30    care delivery resources within a service area or a portion of a  
31    service area may not offer a contract in the area in which the  
32    carrier is not offering coverage to individuals to new employer  
33    groups until the carrier notifies the commissioner that it has the  
34    ability to deliver services to individuals, and certifies to the  
35    commissioner that from the date of the notice it will enroll all  
36    individuals requesting coverage in that area from the carrier unless  
37    the carrier has met the requirements of subdivision (d).

38    (3) Nothing in this article shall be construed to limit the  
39    commissioner's authority to develop and implement a plan of

1 *rehabilitation for a carrier whose financial viability or*  
2 *organizational and administrative capacity has become impaired.*

3 *(c) Offer coverage to an individual or child that, within 12*  
4 *months of application for coverage, disenrolled from a health*  
5 *benefit plan offered by the carrier.*

6 *(d) (1) The commissioner approves the carrier's certification*  
7 *that the number of eligible employees and dependents enrolled*  
8 *under contracts issued during the current calendar year equals*  
9 *or exceeds either of the following:*

10 *(A) In the case of a carrier that administers any self-funded*  
11 *health coverage arrangements in California, 10 percent of the*  
12 *total enrollment of the carrier in California as of December 31 of*  
13 *the preceding year.*

14 *(B) In the case of a carrier that does not administer any*  
15 *self-funded health coverage arrangements in California, 8 percent*  
16 *of the total enrollment of the carrier in California as of December*  
17 *31 of the preceding year. If that certification is approved, the*  
18 *carrier shall not offer any health benefit plan to any small*  
19 *employers during the remainder of the current year.*

20 *(2) If a carrier treats an affiliate or subsidiary as a separate*  
21 *carrier for the purpose of this article because one carrier is*  
22 *qualified under the federal Health Maintenance Organization Act*  
23 *(42 U.S.C. Sec. 300e et seq.) and does not offer coverage to small*  
24 *employers, while the affiliate or subsidiary offers a plan contract*  
25 *that is not qualified under the federal Health Maintenance*  
26 *Organization Act (42 U.S.C. Sec. 300e et seq.) and offers health*  
27 *benefit plans to small employers, the carrier offering coverage to*  
28 *small employers shall enroll new eligible employees and*  
29 *dependents, equal to the applicable percentage of the total*  
30 *enrollment of both the carrier qualified under the federal Health*  
31 *Maintenance Organization Act (42 U.S.C. Sec. 300e et seq.) and*  
32 *its affiliate or subsidiary.*

33 *(3) (A) The certified statement filed pursuant to this subdivision*  
34 *shall state the following:*

35 *(i) Whether the carrier administers any self-funded health*  
36 *coverage arrangements in California.*

37 *(ii) The carrier's total enrollment as of December 31 of the*  
38 *preceding year.*

1     (iii) *The number of eligible employees and dependents enrolled*  
2 *under health benefit plans issued to small employer groups during*  
3 *the current calendar year.*

4     (B) *The commissioner shall, within 45 days, approve or*  
5 *disapprove the certified statement. If the certified statement is*  
6 *disapproved, the carrier shall continue to issue coverage and be*  
7 *subject to disciplinary action.*

8     10958. *The commissioner may require a carrier to discontinue*  
9 *the offering of contracts or acceptance of applications from any*  
10 *individual or child upon a determination by the commissioner that*  
11 *the carrier does not have sufficient financial viability or*  
12 *organizational and administrative capacity to ensure the delivery*  
13 *of health care services to its insureds. In determining whether the*  
14 *conditions of this section have been met, the commissioner shall*  
15 *consider, but not be limited to, the carrier's compliance with the*  
16 *requirements of this part and the rules adopted under those*  
17 *provisions.*

18     10959. *All health benefit plans offered to a child or individual*  
19 *shall be renewable at the option of the insured or responsible party*  
20 *for a child except:*

21     (a) *For nonpayment of the required premiums by the insured*  
22 *or responsible party for a child.*

23     (b) *For fraud or misrepresentation by the individuals or their*  
24 *representatives.*

25     (c) *When the carrier ceases to provide or arrange for the*  
26 *provision of health care services for new individual health benefit*  
27 *plans in this state; provided, however, that the following conditions*  
28 *are satisfied:*

29     (1) *Notice of the decision to cease new or existing individual*  
30 *health benefits plans in this state is provided to the commissioner*  
31 *and to the contractholder at least 360 days prior to the*  
32 *discontinuation of the coverage.*

33     (2) *Individual health benefit plans subject to this article shall*  
34 *not be canceled for 360 days after the date of the notice required*  
35 *under paragraph (1) and for that business of a carrier which*  
36 *remains in force, any carrier that ceases to offer for sale new*  
37 *individual health benefit plans shall continue to be governed by*  
38 *this article with respect to business conducted under this article.*

39     (3) *Except as authorized under subdivision (d) of Section 10957*  
40 *or Section 10959, a carrier that ceases to write new individual*

1 *business in this state after the effective date of this article shall be*  
2 *prohibited from offering for sale new individual health benefit*  
3 *plans in this state for a period of five years from the date of notice*  
4 *to the commissioner.*

5 *(d) When the carrier withdraws a health benefit plan from the*  
6 *individual market; provided, the carrier notifies all affected*  
7 *contractholders and the commissioner at least 180 days prior to*  
8 *the discontinuation of those contracts, and the carrier makes*  
9 *available to the individual all health benefit plans that it makes*  
10 *available to new individual business; and provided, that the*  
11 *premium for the new health benefit plan complies with the renewal*  
12 *increase requirements set forth in Section 10960.*

13 *10960. Effective January 1, 2011, premiums for contracts*  
14 *offered or delivered by carriers on or after the effective date of*  
15 *this article for children shall be subject to the following*  
16 *requirements:*

17 *(a) The premium for new business shall be determined for an*  
18 *eligible child in a particular risk category after applying a risk*  
19 *adjustment factor to the carrier's standard risk rates. The risk*  
20 *adjusted risk rate may not be more than 120 percent or less than*  
21 *80 percent of the carrier's applicable standard risk rate until*  
22 *January 1, 2012. Effective January 1, 2012, this factor may not*  
23 *be more than 110 percent or less than 90 percent. The standard*  
24 *risk rates applied to a child for new business shall be in effect for*  
25 *no less than 12 months.*

26 *(b) (1) The premium for in force business shall be determined*  
27 *for an eligible child in a particular risk category after applying a*  
28 *risk adjustment factor to the carrier's standard individual risk*  
29 *rates. The risk adjusted individual risk rates may not be more than*  
30 *120 percent or less than 80 percent of the carrier's applicable*  
31 *standard risk rate until January 1, 2011. Effective January 1, 2012,*  
32 *this factor may not be more than 110 percent or less than 90*  
33 *percent. The factor effective January 1, 2011, shall apply to in*  
34 *force business at the earlier of either the time of renewal or*  
35 *January 1, 2012. The risk adjustment factor applied to a child may*  
36 *not increase by more than 10 percentage points from the risk*  
37 *adjustment factor applied in the prior rating period. The risk*  
38 *adjustment factor for a child may not be modified more frequently*  
39 *than once every 12 months.*

1     (2) *The standard risk rates shall be in effect for no less than 12*  
2 *months.*

3     (3) *For a contract that a carrier has discontinued offering, the*  
4 *risk adjustment factor applied to the standard risk rates for the*  
5 *first rating period of the new contract that the responsible party*  
6 *for the child elects to purchase shall be no greater than the risk*  
7 *adjustment factor applied in the prior rating period to the*  
8 *discontinued contract. However, the risk adjusted individual risk*  
9 *rate may not be more than 120 percent or less than 80 percent of*  
10 *the carrier's applicable standard risk rate until January 1, 2012.*  
11 *Effective January 1, 2012, this factor may not be more than 110*  
12 *percent or less than 90 percent. The factor effective January 1,*  
13 *2012, shall apply to in force business at the earlier of either the*  
14 *time of renewal or January 1, 2012. The risk adjustment factor for*  
15 *a child may not be modified more frequently than once every 12*  
16 *months.*

17     10961. *Carriers shall apply standard risk rates consistently*  
18 *with respect to all children.*

19     10962. *In connection with the offering for sale of any health*  
20 *benefit plan for children, each carrier shall make a reasonable*  
21 *disclosure, as part of its solicitation and sales materials, of the*  
22 *following:*

23     (a) *The extent to which premium rates for a specific child are*  
24 *established or adjusted in part based upon the actual or expected*  
25 *variation in service costs or actual or expected variation in health*  
26 *condition of the child.*

27     (b) *The provisions concerning the carrier's right to change*  
28 *premium rates and the factors, other than provision of services*  
29 *experience, that affect changes in premium rates.*

30     (c) *Provisions relating to the guaranteed issue and renewal of*  
31 *contracts.*

32     (d) *Provisions relating to the child's right to apply for any*  
33 *contract written, issued, or administered by the carrier at the time*  
34 *of application for a new health benefit plan, or at the time of*  
35 *renewal of a health benefit plan.*

36     (e) *The availability, upon request, of a listing of all the plan's*  
37 *contracts and benefit plan designs offered for children, including*  
38 *the rates for each contract.*

39     (f) *At the time it offers a contract to the responsible party for a*  
40 *child, each carrier shall provide the responsible party with a*



1 *statement of all of its health benefit plans offered to children,*  
2 *including the rates for each health benefit plan, in the service area*  
3 *in which the individuals who are to be covered by the health benefit*  
4 *plan reside. For purposes of this subdivision, carriers that are*  
5 *affiliated carriers or that are eligible to file a consolidated income*  
6 *tax return shall be treated as one carrier.*

7 *(g) Each carrier shall do all of the following:*

8 *(1) Prepare a brochure that summarizes all of its health benefit*  
9 *plans offered to children and to make this summary available to*  
10 *any responsible party for a child and to solicitors upon request.*  
11 *The summary shall include for each contract information on*  
12 *benefits provided, a generic description of the manner in which*  
13 *services are provided, such as how access to providers is limited,*  
14 *benefit limitations, required copayments and deductibles, standard*  
15 *risk rates, and a phone number that can be called for more detailed*  
16 *benefit information. carriers are required to keep the information*  
17 *contained in the brochure accurate and up to date and, upon*  
18 *updating the brochure, send copies to solicitors and solicitor firms*  
19 *with whom the health benefit plans to solicit enrollments or*  
20 *subscriptions.*

21 *(2) For each contract, prepare a more detailed evidence of*  
22 *coverage and make it available to responsible parties, solicitors,*  
23 *and solicitor firms upon request. The evidence of coverage shall*  
24 *contain all information that a prudent buyer would need to be*  
25 *aware of in making contract selections.*

26 *(3) Provide to responsible parties and solicitors, upon request,*  
27 *for any given child the standard risk rates. When requesting this*  
28 *information, responsible parties, solicitors, and solicitor firms*  
29 *shall provide the carrier with the information the carrier needs to*  
30 *determine the individual's risk adjusted risk rate.*

31 *(4) Provide copies of the current summary brochure to all*  
32 *solicitors and solicitor firms contracting with the carrier to solicit*  
33 *enrollments or subscriptions from responsible parties for children.*

34 *For purposes of this subdivision, carriers that are affiliated*  
35 *carriers or that are eligible to file a consolidated income tax return*  
36 *shall be treated as one carrier.*

37 *(h) Every solicitor or solicitor firm contracting with one or more*  
38 *carriers to solicit enrollments or subscriptions from responsible*  
39 *parties for children shall do all of the following:*

1     (1) When providing information on contracts to a responsible  
2 party for a child or children but making no specific  
3 recommendations on particular health benefit plans:

4     (A) Advise the responsible party of the carrier's obligation to  
5 sell to any responsible party any health benefit plan it offers for  
6 children and provide them, upon request, with the actual rates that  
7 would be charged for that child for a given contract.

8     (B) Notify the responsible party that the solicitor or solicitor  
9 firm will procure rate and benefit information for the responsible  
10 party for the child on any health benefit plan offered by a carrier  
11 whose contract the solicitor sells.

12     (C) Notify the responsible party that upon request the solicitor  
13 or solicitor firm will provide the responsible party with the  
14 summary brochure required under this paragraph for any health  
15 benefit plan offered by a carrier with whom the solicitor or solicitor  
16 firm has contracted to solicit enrollments or subscriptions.

17     (2) When recommending a particular benefit plan design or  
18 designs, advise the responsible party that, upon request, the agent  
19 will provide the responsible party with the brochure required by  
20 paragraph (1) containing the benefit plan design or designs being  
21 recommended by the agent or broker.

22     (3) Prior to filing an application for a responsible party for a  
23 child for a particular contract:

24     (A) For each of the health benefit plans offered by the carrier  
25 whose contract the solicitor or solicitor firm is offering, provide  
26 the responsible party with the benefit summary required in  
27 paragraph (1) and the standard risk rates for that particular child.

28     (B) Notify the responsible party that, upon request, the solicitor  
29 or solicitor firm will provide the responsible party with an evidence  
30 of coverage brochure for each contract the carrier offers.

31     (C) Notify the responsible party for a child that, from January  
32 1, 2011, to January 1, 2012, actual rates may be 20 percent higher  
33 or lower than the standard risk rates, and from January 1, 2012,  
34 until December 31, 2014, actual rates may be 10 percent higher  
35 or lower than the standard risk rates, depending on how the carrier  
36 assesses the risk of the child.

37     (D) Notify the responsible party that, upon request, the solicitor  
38 or solicitor firm will submit information to the carrier to ascertain  
39 the child's the risk adjusted risk rate for any contract the carrier  
40 offers.

1 (E) Obtain a signed statement from the responsible party  
2 acknowledging that the responsible party has received the  
3 disclosures required by this section.

4 10963. (a) At least 30 business days prior to renewing or  
5 amending a health benefit plan subject to this article that will be  
6 in force on the operative date of this article, a carrier shall file a  
7 notice of material modification with the commissioner. The notice  
8 of material modification shall include a statement certifying that  
9 the carrier is in compliance with subdivision (j) of Section 10950  
10 and Section 10960. The certified statement shall set forth the  
11 standard risk rate for each risk category and the highest and lowest  
12 risk adjustment factors that will be used in setting the rates at  
13 which the contract will be renewed or amended. Any action by the  
14 commissioner to disapprove, suspend or postpone the carrier's  
15 use of a health benefit plan shall be in writing, specifying the  
16 reasons that the health benefit plan is not in compliance with the  
17 requirements of this chapter.

18 (b) At least 30 business days prior to offering a health benefit  
19 plan subject to this article, all carriers shall file a notice of  
20 material modification with the commissioner. The notice of  
21 material modification shall include a statement certifying that the  
22 carrier is in compliance with subdivision (j) of Section 10950 and  
23 Section 10960. The certified statement shall set forth the standard  
24 risk rate for each risk category and the highest and lowest risk  
25 adjustment factors that will be used in setting the rates at which  
26 the contract will be offered. Carriers that will be offering to a  
27 responsible party for a child contracts approved by the  
28 commissioner prior to the effective date of this article shall file a  
29 notice of material modification in accordance with this subdivision.  
30 Any action by the commissioner to disapprove, suspend, or  
31 postpone the carrier's use of a health benefit plan shall be in  
32 writing, specifying the reasons that the health benefit plan is not  
33 in compliance with the requirements of this chapter.

34 (c) Prior to making any changes in the risk categories, risk  
35 adjustment factors or standard risk rates filed with the  
36 commissioner pursuant to subdivision (a) or (b), the carrier shall  
37 file, as an amendment, a statement setting forth the changes and  
38 certifying that the carrier is in compliance with subdivision (j) of  
39 Section 10950 and Section 10960. A carrier may commence  
40 offering health benefit plans utilizing the changed risk categories

1 set forth in the certified statement on the 45th day from the date  
2 of the filing, or at an earlier time determined by the commissioner,  
3 unless the commissioner disapproves the amendment by written  
4 notice, stating the reasons therefor. If only the standard risk rate  
5 is being changed, and not the risk categories or risk adjustment  
6 factors, a carrier may commence offering health benefit plans  
7 utilizing the changed standard risk rate upon the 31st day after  
8 filing the certified statement unless the commissioner disapproves  
9 the amendment by written notice.

10 (d) Periodic changes to the standard risk rate that a carrier  
11 proposes to implement over the course of up to 12 consecutive  
12 months may be filed in conjunction with the certified statement  
13 filed under subdivision (a), (b), or (c).

14 (e) Each carrier shall maintain at its principal place of business  
15 all of the information required to be filed with the commissioner  
16 pursuant to this section.

17 (f) Each carrier shall make available to the commissioner, on  
18 request, the risk adjustment factor used in determining the rate  
19 for any particular child.

20 (g) Nothing in this section shall be construed to limit the  
21 commissioner's authority to enforce the rating practices set forth  
22 in this article.

23 10964. The commissioner may issue regulations that are  
24 necessary to carry out the purposes of this article. Prior to the  
25 public comment period required by regulations under the  
26 Administrative Procedure Act (Chapter 3.5 (commencing with  
27 Section 11340) of Part 1 of Division 3 of Title 2 of the Government  
28 Code), the commissioner shall provide the Director of Managed  
29 Health Care with a copy of the proposed regulations. The director  
30 shall have 30 days to notify the commissioner in writing of any  
31 comments on the regulations. The director's comments shall be  
32 included in the public notice issued on the regulations. Any rules  
33 and regulations adopted pursuant to this article may be adopted  
34 as emergency regulations in accordance with the Administrative  
35 Procedure Act. Until December 31, 2015, the adoption of these  
36 regulations shall be deemed an emergency and necessary for the  
37 immediate preservation of the public peace, health and safety, or  
38 general welfare. Any regulations adopted prior to December 31,  
39 2015, in order to remain in effect after December 31, 2016, shall

1 *be readopted as nonemergency regulations in accordance with*  
2 *the Administrative Procedures Act prior to December 31, 2016.*

3 *SEC. 3. No reimbursement is required by this act pursuant to*  
4 *Section 6 of Article XIII B of the California Constitution because*  
5 *the only costs that may be incurred by a local agency or school*  
6 *district will be incurred because this act creates a new crime or*  
7 *infraction, eliminates a crime or infraction, or changes the penalty*  
8 *for a crime or infraction, within the meaning of Section 17556 of*  
9 *the Government Code, or changes the definition of a crime within*  
10 *the meaning of Section 6 of Article XIII B of the California*  
11 *Constitution.*

12 ~~SECTION 1. Section 13291 of the Government Code is~~  
13 ~~amended to read:~~

14 ~~13291. The department may require financial and statistical~~  
15 ~~reports, duly verified and covering the period of each fiscal year,~~  
16 ~~from all agencies of the state included within the provisions of~~  
17 ~~Section 13300.~~

18 ~~Reports shall be made upon blank forms prescribed and furnished~~  
19 ~~by the department, and mailed to each such agency not less than~~  
20 ~~60 days before the time the reports are required to be filed with~~  
21 ~~the department.~~